STATE OF MONTANA,
MONTANA UNIVERSITY SYSTEM,
MONTANA POWER COMPANY, and
FIRST INTERSTATE BANCSYSTEM

PRESCRIPTION DRUG CLAIM AUDIT

FOR THE PERIOD

JULY 1, 1999 THROUGH JUNE 30, 2000

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena, MT 59620-1705

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FOR THE PERIOD

JULY 1, 1999 THROUGH JUNE 30, 2000

ADMINISTERED BY

EXPRESS SCRIPTS

FINAL REPORT

NOVEMBER, 2000

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
10977 GRANADA LANE, SUITE 103
OVERLAND PARK, KANSAS 66211

STATE OF MONTANA
PRESCRIPTION DRUG PLAN AUDIT
OF EXPRESS SCRIPTS
JULY 1, 1999 - JUNE 30, 2000

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I - INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 13,500 employees and retirees, plus their dependents.

The State is a member of the Montana Association of Health Care Purchasers. The Assocation has negotiated a contract with Express Scripts, Inc.(ESI) to provide prescription drug benefits to employees and Association members that elect such benefits. The State has elected to have its prescription drug benefits provided by Express Scripts, Inc.

The Montana Power Company (MPC) and First Interstate Bank (FIB), both members of the Association, have also contracted to have their prescription drug benefits provided by ESI. The Montana University System (MUS), has contracted directly with ESI for the provision of prescription drug benefits.

The State invited the other three plan sponsors to participate in an audit of ESI's processing of prescription drug claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. The Division issued a bid request on May 25, 2000, for the performance of this audit. Wolcott & Associates, Inc. was awarded the audit contract.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and the other three plan sponsors recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. All four sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the entrance meeting was held in Helena on July 25, 2000. On-site work at the State, MPC, MUS, FIB and Blue Cross and Blue Shield of Montana (BCBSMT), the organization that manages eligibility and other plan services for two of

of the plan sponsors, was performed during the week of July 24, 2000.

The on-site work started on August 17, 2000 at the ESI's St. Louis corporate office.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
2500 Broadway
Helena, Montana 59620

The Montana Power Company
40 East Broadway
Butte, Montana 59701

First Interstate Bank of Billings, N.A.
401 North 31st Street
Billings, Montana 59116-0918

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Express Scripts, Inc.
13900 Riverport Drive
Maryland Heights, Missouri 63043

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Ray Wolcott, Jr.	President, Project Manager	Yes
Brian Wyman	Manager	Yes
Marie Richman	Senior Auditor	No
Richard Reese	Actuary	No
Sue Weydert	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by ESI during the period from July 1, 1999 through June, 30 2000. Test work was performed on 211 previously processed claims, all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Confirmation of receipt of prescription.
- Administration of coordination of benefits and subrogation provisions.
- Calculation accuracy.
- Completeness of necessary information.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

Test Claims

Test claims were prepared and entered into the ESI system to test various aspects of the system's capabilities. The test claims addressed the following:

- Claims for terminated individuals.
- Claims for terminated dependents.
- Claims from a fictitious provider.
- Claims for drug prices in excess of the contract price.
- Claims for medication inconsistent with the patient's sex.

LIST OF ADMINISTRATIVE OFFICIALS

Listings of administrative officials for both the Department of Administration and ESI are presented below.

Department of Administration administrative officials at the time of our audit, included:

Acting Director, Department of Administration - Dave Ashley
Administrator, State Personnel Division - John McEwen
Chief Employee Benefits Bureau - Joyce Brown
Operations Supervisor - Kari Brustkern

ESI administrative officials at the time of our audit, included:

Account Manager - Cyndi Olivarez
Client Audit Coordinator - Christina Norman
Director Internal Audit - Doug Menendez

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims.

The claims were selected from the population of claims paid by ESI between July 1, 1999 and June 30, 2000. Prior to selection, the population of claims was stratified. Information regarding the population strata and the sample strata are presented below.

STRATIFIED POPULATION AND SAMPLE DATA

		Population		Sample	
Strata	Description	Number	Total Dollars	Number	Total Dollars
1	Payments Exceeding $3,082.33	33	$ 122,373.44	33	$ 122,373.44
2	Payments Between $232.38 and $3082.33	9,773	$4,309,502.84	40	$ 16,403.55
3	Payments Between $99.85 and $232.38	29,295	$4,309,663.04	40	$ 5,820.01
4.	Payments Between $46.95 and $99.85	65,791	$4,309,713.06	35	$ 2,266.75
5.	Payments Between $0.1 and $46.95	282,959	$4,309,632.25	43	$ 631.73
6.	Zero Payment Claims	5,823	$ 0.00	20	$ 0.00
	Total	393,674	$17,360,884.63	211	$147,495.48

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on each plan's provisions in force as of the date the prescription was dispensed. Ingredient costs were calculated based on Average Wholesale Prices (AWP) or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, administration fees, deductible and copayment amounts were compared to each plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan requirements for:

- Exclusions,
- Appropriate copayment (generic, branded, etc.),
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and
- Maintenance versus acute care.

DEFINITION OF ERROR

All paper filed claims were paid to the participant. All network pharmacy (electronic claims) were paid to the pharmacist.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 claims in our statistical sample, 30 were judged to contain a payment error. This represents a frequency of payment error of 14.2%. Of these 30 claims, 26 were overpayments and 4 were underpayments.

Our sample contained a total payment of $147,495.48 for the 211 claims. The overpayments totaled $3,859.72 or 2.6% of the total. The underpayments totaled $166.85 or .11% of the total.

The frequency of payment error in our sample exceeded the frequency of errors typically found by Wolcott & Associates, Inc. during similar audits. Based on our experience, the frequency of payment error in card driven prescription drug programs typically does not exceed 1.0% and the magnitude of payment error seldom exceeds 0.5%.

The sample of 211 claims was not large enough, due to the 14.2% error rate, to allow us to express our results with a 95% confidence level + or - 3%. We did advise the Association of this and offered to audit additional claims at their expense. However, we also advised the Association that we did not believe the error rate would be any better due to the types of errors identified in the audit sample (i.e. system and programming errors). As a result, we were advised, by the Association, that no increase in the sample was necessary.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 7.3%, that the true frequency of error in the population ranges from 6.9% to 21.5%.

Based on this extension, we believe that the true magnitude of payment error in the population is $436,517 or (2.5%). The magnitude of payment error is the sum of $277,224 in projected overpayments plus $159,293 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

The most common error type involved ESI failure to use the correct discount on mail order drugs. This type of error occurred six times. Four of the errors occurred because of the incorrect calculation of ingredient cost. Three of the errors involved the incorrect calculation of the co-pay amount.

Two errors occurred as a result of the calculation of AWP on the date the bill was received rather than on the date the prescription was dispensed. The documents all refer to the use of current AWP information. Both network and paper claims are processed based on AWP as of the date the prescription is filled.

Two errors occurred because the ingredient cost was calculated using billed charges when AWP less the discount was lower. Two other errors occurred because the ingredient cost was calculated using AWP less the applicable discount when the billed charges were lower. One error occurred because the ingredient cost was calculated using the pharmacy's billed charges when ESI's usual and customary charges were lower.

Another error occurred because the claim was calculated using AWP less the discount when the MAC price was lower which caused an overstatement of the participant's deductible.

Two errors occurred because claim payment was calculated using pricing for generic when the prescription filled was a brand name drug.

Two claims were in error due to the ESI failure to charge the correct administrative fee.

Finally, five paper claims were processed based on billed charges rather than AWP less the discount.

A summary of error by type is presented below:

EXPRESS SCRIPTS PHARMACY CLAIMS
JULY 1, 1999 THROUGH JUNE 30, 2000
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect discount for mail order claims.	6	$ 25.44
Paper claims paid based on submitted cost instead of network cost.	5	3,507.26
Incorrectly calculated the ingredient cost.	4	209.34

Incorrect copay applied.	3	20.19
Ingredient cost was calculated using outdated AWP.	2	(20.08)
AWP less discount lower than billed ingredient cost.	2	3.86
Billed ingredient cost is lower than AWP less discount.	2	88.89
ESI U&C is lower than pharmacy's submitted U&C.	1	0.50
MAC cost is lower than AWP less the discount.	1	0.00
Incorrectly applied a generic discount for a brand name drug.	2	(146.77)
Incorrect administration fee.	2	4.24
Total	30	$3,692.87

OUT- OF- POCKET LIMIT

During our audit of the sample claims we noted three participants' deductible and copays that, in total, exceeded their out-of-pocket limit for the plan year. It appears the ESI system cannot track the out-of-pocket limit properly. The three participants exceeded their out-of-pocket limits in the amount of $60.00, $50.68 and $153.38 respectively.

III - PARTICIPANT CONFIRMATIONS

Our work plan included the preparation and mailing of 125 confirmations to participants who had received prescriptions under the plan. The results are discussed below.

A separate sample of claims processed during May and June 2000 was selected for confirmation purposes. While it was possible that the sample would include both electronic and paper filed claims, no paper filed claims were identified in the confirmation sample.

The address for each claimant was obtained from the plan sponsor. A letter, requesting confirmation of the prescription, was mailed to each.

We received 92 responses to our initial confirmation request. Contact by telephone was made to the participants who did not respond to the initial confirmation. We also requested the assistance of the plan sponsors in contacting 32 of the participants.

All but 27 of the 125 participants eventually responded.

Of those that responded, all but 6 confirmed that the prescription was received and that the copay agreed with the records at ESI. Each of the 6 that did not agree with ESI records are discussed below.

One participant reported that her date of birth was different than what was shown on the ESI system. We contacted the State and they confirmed that the participant's date of birth was different than ESI. The State suggested that the payroll clerk entered that date of birth incorrectly. However, when the date of birth had been corrected, the change had not been sent to ESI before our confirmation was sent. We contacted ESI and they confirmed their system shows the date of birth that is in agreement with the participant.

- Three participants reported their last name did not match with the confirmation. We contacted the participants and all indicated that the last name on the confirmation was their maiden name and they were married between the date of their prescription and our confirmation.

- One participant reported that she paid a copayment amount greater than the amount shown on the ESI system. We contacted the participant and she stated that she looked at the wrong prescription. The prescription she indicated the greater copay was a prescription filled after the selected prescription. She then agreed that the copay was correct. We contacted the pharmacy and obtained a copy of the receipt showing an amount that agreed with the ESI report.

- One participant reported that the dosage was lower than indicated on our confirmation. We contacted the pharmacy and obtained a copy of the receipt showing a dosage amount that agreed with ESI report. We also noted that this participant had a different

prescription filled that date, which coincided with the dosage that she indicated she had received that day.

We have no reason to believe there were irregularities regarding the services provided to the individuals we were unable to contact.

Based on the results of our confirmation activity, we conclude that prescriptions reported on the ESI system are actually being dispensed.

No exceptions were noted.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to ESI. This section describes the methods employed and presents the results of the verification of eligibility for the 211 of the claims in our sample, plus an additional 60, that were not in our audit sample where a payment was made by ESI.

STATE OF MONTANA

The State prepares and sends to ESI a biweekly eligibility tape showing each individual to be covered for the coming month. ESI runs this tape and compares it to the data for the prior month. A reconciliation report is produced by ESI showing each person whose coverage is to terminate as of the last day of the month prior to the date for which the new eligibility data applies.

ESI sends the reconciliation report to the State and requests confirmation that everyone on the list should be terminated.

Each month the State confirms that those people should have their coverage terminated at the end of the month.

Eligibility Verification

Each of the 113 State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the prescription was dispensed.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

BCBSMT processes claims for the MUS health care plan. BCBSMT has also contracted to provide eligibility data to ESI on behalf of MUS. BCBSMT receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to ESI electronically each day.

Eligibility Verification

Each of the 61 MUS participants in our sample was researched on the BCBSMT eligibility system to verify that the MUS's records indicated that coverage was in force on the date the prescription was dispensed. MUS records confirmed that 60 participants were covered as of the date the prescription was dispensed.

One individual's coverage had terminated prior to the date a prescription was dispensed. BCBSMT system indicated that the term date was 8/31/99. ESI's records indicate that they were not notified until 10/6/99 of the term date. This participant had a prescription filled on 9/9/99.

No other exceptions were noted.

THE MONTANA POWER COMPANY

MPC has also engaged BCBSMT to process and transmit eligibility data to ESI. The process is similar to that performed at MUS by BCBSMT.

Eligibility Verification

We researched MPC's employment records for each of the 28 selected claimants. MPC's records confirmed that 27 participants were covered as of the date the prescription was dispensed.

One individual on MPC's system indicates that their coverage had terminated prior to the date a prescription was dispensed. ESI's records show that they were never notified of the termination. We have discussed the situation with MPC and with the Client Audit Coordinator in St. Louis.

No other exceptions were noted.

FIRST INTERSTATE BANK

Intermountain Administrators, Inc. (IAI) processes claims for the FIB health care plan. As of January 1, 2000, IAI has also contracted to provide eligibility data to ESI on behalf of FIB. IAI receives the enrollment data from FIB upon notification from a participant and transmits new entrant, change and termination data to ESI electronically every Friday. Prior to January 1, 2000, FIB had direct, on-line access to the ESI system for the purpose of updating participant eligibility. FIB processed all eligibility transactions, as they occurred, directly into the ESI system.

Eligibility Verification

We researched the FIB employment records for each of the 69 selected claimants (60 additional claims not in our audit sample and 9 claims in our audit sample). FIB records confirm that 67 were covered on the date the selected prescription was dispensed.

One individual changed their coverage from family coverage to single coverage. ESI's records show that they were never notified of the change in coverage.

Another individual's coverage had terminated prior to the date a prescription was dispensed. This individual cannot be located in FIB's system. We obtained paper records and the termination date was in 1989. ESI's records show that they were informed to terminate this individual on 7/5/2000.

We have discussed these two situations with FIB and with the Client Audit Coordinator.

No other exceptions were noted.

V - CLAIM PAYMENT AND ESI REIMBURSEMENT

The scope of our service included the measurement of two time periods: (1) the time required by ESI to process claims and reimburse pharmacies and participants and (2) the time required by the plan sponsors to reimburse ESI. The results of our test work for both measures are presented below.

CLAIM PAYMENT TIME

ESI processes most claims electronically. Under this method, the patient presents an identification card containing information, including the participant's Social Security number, plan sponsor's name and the plan's copayment and deductible provisions.

The pharmacist fills the prescription and enters the required data into the ESI system using the pharmacy's computer. The system calculates the copay amount, amount to be charged to the plan sponsor and the amount to be paid to the pharmacy.

Pharmacies are then reimbursed on a cycle specified in their contract with ESI.

Participants who elect to use non-ESI member pharmacies, participants who have not yet received an ESI card and State participants whose ESI coverage is subject to the COB provision, must file their claims directly with ESI.

These claims are manually processed by ESI and checks are prepared and mailed to the participant.

We measured the time required to pay pharmacists as the elapsed calendar days between the date the prescription was dispensed and the date ESI issued the check.

Our results are presented below. The results are for 191 claims. No elapsed time was measured for the following:

- Adjusting entries and
- Claims with no payment.

Paper Claims Results

Our sample included seven paper claims that had been filed by participants. Three of these were State employees, three were MUS employees and one was a MPC employee. Overall results for paper claims were measured from the date the prescription was dispensed to the date ESI issued the payment to the participant.

During our review, we requested the received date information for the paper claims. Therefore, the results detailed below are based on actual received date rather than dispense date.

Measure	Elapsed Days
Mean	49
Median	7
Mode	7

ESI informed us that company policy for turnaround time for paper claims is three working days.

Electronic Claim Results

Overall results from the measurement of the time required by ESI to pay pharmacists shows the following as measured from the date the prescription is dispensed to the date ESI issues the payment to the pharmacy.

Measure	Elapsed Days
Mean	12
Median	9
Mode	1

Information for each of the four plan sponsors is presented as **Exhibit B.**

REIMBURSEMENT PROCESSING TIME

ESI submits invoices for reimbursement for prescriptions dispensed and their administrative fees. The frequency of the invoices and the payment terms differ for each plan sponsor. Presented below is information regarding the contractual provision and the actual time required to reimburse ESI based on records made available to us.

State of Montana

The agreement requires a bank wire transfer within 48 hours of the receipt of the invoice to ESI.

We gathered invoices from July 1, 1999 through June 30, 2000 and measured the elapsed time between the invoice date and the date payment was made by the State. To adjust for mail time, we allowed 3 days. Measurement was therefore based on 18 calendar days (3 weeks less 3 days).

A total of 25 invoices were included in our review. Two invoices were paid in less than 8 days. We were unable to identify a received date stamp on any of the invoices. However, allowing 3 days for mail delivery, none of the invoices were paid within 48 hours of receipt.

Montana University System

All reimbursement by MUS during the audit period were made by bank wire transfer either on the date the invoice was received or the following day. As a result, we conclude that MUS has complied with the ESI reimbursement requirements even if they required wire transfer within 48 hours of receipt of the invoice.

MUS recorded the received date for all invoices. We measured the elapsed time from the invoice date to the received date recorded by MUS.

The Montana Power Company

The ESI agreement describing reimbursement is contained in an agreement between ESI and BCBSMT. The agreement calls for reimbursement within 15 business days of the date of the invoice. As with State, we measured based on 18 calendar days to adjust for the mail time from Helena to St. Louis.

ESI sends BCBSMT two invoices per month for MPC. Of the 24 invoices reviewed, 2 required more than 18 days to pay.

Each of the 24 invoices contained a "Net 30 Day" payment term. All 24 invoices were paid within 30 days of the invoice date.

BCBSMT does date stamp the invoices when received. However, we were unable to read the received dates on 2 of the copies provided to us. The elapsed time between the invoice date and the received date stamped by BCBSMT ranged from five to eleven days.

First Interstate Bank

The FIB agreement provided to us states that FIB will reimburse ESI by bank wire transfer within 48 hours of receipt of the invoice. Invoices were received once a month. We reviewed 12 invoices. None of the invoices contained received date stamps indicating when they were received by FIB. The elapsed time between the invoice date and the payment date ranged from four days to eleven days. All invoices were paid within 14 days of the invoice date.

Comment

The contractual reimbursement terms and the payment terms on each invoice are in conflict.

ESI has repeatedly accepted reimbursements after the date specified in the agreements for three plan sponsors without imposing a late payment penalty. We believe such action has effectively waived any penalties and ESI would be stopped from prospectively or retroactively imposing such penalties for the duration of their agreements with the three plan sponsors.

VI - EXPRESS SCRIPTS COMPLIANCE

This section discusses the results of our review of the compliance with State regulations and contract provisions.

STATE REGULATIONS

Sections 37.7.101 through 37.7.712, MCA address the regulation of pharmacies. Section 37.7.701 through 37.7.712 present regulations for Out-Of-State Mail Service Pharmacies.

The four plan sponsors, whose plans are the subject of this report, have elected to utilize a Montana domiciled mail service pharmacy. ESI operates an Out-Of-State Mail Service Pharmacy, however, this service is not being used by the four plan sponsors.

We are unaware of any other State regulations applicable to the provision of pharmacy benefit services. We conclude, based on our review, that ESI is in compliance with State regulations.

CONTRACT PROVISIONS

ESI has entered into contracts with the Association and each plan sponsor. Information regarding our review of these contracts is presented below.

ASSOCIATION AGREEMENT

The contract between the Association and ESI was renewed as of April 1, 1999. The contract specifies the services to be provided by ESI. This agreement relates to the plans sponsored by the State, MPC and FIB. These services include:

- Accurate processing of claims based on plan provisions and agreed upon pricing.
- Audits of participating pharmacies.
- Drug Utilization Review services.
- Preparation of reports.
- Coordination of benefits claim processing.

The results of our review of these activities are presented below.

Accurate Processing of Claims

Prescription drug claim processors typically encounter delays between the effective date of a change in the Average Wholesale Price (AWP) of a drug and the date that the information is loaded into the claim processing system. We accept the fact that delays will occur. To the extent that drug prices tend to increase more than decrease, the delay does not tend to increase the cost of prescription drugs for the participants or the plan sponsors.

However, we do find it worth noting that pharmacies tend to utilize the new AWP information more rapidly than those who process such claims.

Based on the results of our audit of previously processed claims, we conclude:

- The ESI system is not capable of limiting a participant's out-of-pocket expense to the dollar limit specified in the Plan document.
- The ESI system is not capable of processing claims with a high degree of accuracy.
- ESI personnel responsible for updating the administration fees based on changes to plan provisions appear to be inconsistent with agreed upon fees in the contract.
- ESI personnel responsible for payment on member submitted claims is inconsistent with agreed upon payments in the contract.

Other comments regarding the accuracy of claim payments are presented in Section II.

Audit of Participating Pharmacies

ESI has the right to audit participating pharmacies. ESI agrees to pay the plan sponsors 80% of all overpayments recovered during such audits.

Audit recovery information was obtained from ESI. In 1995, ESI's prescription drug program had audits with $1,000,000 dollars recovered. In 1996, ESI's prescription drug program had audits with $2,100,000 dollars recovered. In 1997, ESI's prescription drug program had audits with $2,800,000 dollars recovered. In 1998, ESI's prescription drug program had audits with $3,500,000 dollars recovered. In 1999 ESI's prescription drug

program had a projected recoveries of $4,500,000.

ESI provided documentation regarding the conduct of such audits in the State of Montana and MUS.

Plan Sponsor	Year	Dollars Recovered
State of Montana	1999	$ 5,737.72
State of Montana	1st Quarter of 2000	3,324.97
MUS	1999	80.21
MUS	1st Quarter of 2000	1,762.96

ESI informed us that MPC and FIB do not participate in this audit recovery program.

Drug Utilization Review

ESI has agreed to conduct DUR services. These services include a review of:

- Drug-to-drug interactions,
- Drug allergy interactions,
- Drug-to-age interactions,
- Drug-to-medical condition interactions,
- Duplicate prescription,
- Exceeding maximum dosage,
- Refill too soon,
- Drug dosage and
- Therapeutic duplications.

Without detailed medical information, ESI cannot review medical condition interactions or allergy interactions.

We noted when a paper claim is received, ESI enters a one day supply into the system when in fact the prescribed supply could be for 90 days. ESI confirmed that this could cause a participant to receive a refill too soon.

The system does appear to be adequate to identify duplicate claims.

We conclude that the ESI DUR service may not be in compliance with the contractual agreement with the Association as it relates to the refill too soon edit.

Coordination of Benefits Claim Processing

COB data are not being provided to ESI. When the State first adopted the ESI program, COB data from BCBSMT was provided to ESI. However, no further information has been provided by the State or BCBSMT.

COB data are not being provided to ESI by or on behalf of any of the other 3 plan sponsors.

Conclusion

Based on the results of our review, we conclude that ESI may be in compliance with the terms of the Association contract except as it relates to the DUR service and the accurate processing of claims. We believe the DUR service may be ineffective in identifying abuse or inappropriate medications for the reasons cited above. The ESI claim processing system did not process claims with an accuracy rate similar to other systems with which we are familiar.

ESI may be in compliance with other aspects of the agreement. However, we received no documentation permitting us to reach a conclusion.

STATE CONTRACT

ESI and the State have entered into an agreement which was renewed as of April 1, 1999. The terms of the agreement relate to the specifics of the State's benefit plan provision. However, the terms of the Association agreement also apply to the State. We conclude that ESI is not complying with the terms of its agreement with the State in the same areas in which they do not comply with the Association agreement.

MUS CONTRACT

ESI entered into a renewed contract with MUS as of July 1, 1997. The scope of the MUS contract is similar to that of the contract with the Association. However, ESI has agreed to additional services, including:

- Incentive payments and formulary rebates,
- Drug therapy management program,
- Member and Physician education and
- Performance and cost savings guarantees.

All comments regarding the Association contract are applicable to the MUS contract review.

Incentive Payments and Rebates

ESI has been providing MUS periodic payments and rebates. We recalculated the client share of the formulary rebate and noted no exceptions. However, ESI would not provide information on the dollar amount paid to the drug manufacture for each formulary drug. Not having this information, Wolcott & Associates, Inc. could not obtain assurance that the formulary rebate from the manufacture to ESI was the correct amount.

Drug Therapy Management Program

ESI reported that the Drug Therapy Management Program is in place and physicians are being contacted and encouraged to use preferred drugs. We are aware that MUS is being charged for this service and conclude that the performance is in compliance with the contract.

Member and Physician Education

ESI has agreed to mail letters to participants and physicians designed to educate both groups about the use of lower cost generic medications. No documentation was provided to confirm that these services are still being performed. We understand this provision was removed from the Association's agreement. However, it is still part of the MUS agreement.

Performance and Cost Saving Guarantees

ESI has agreed to penalties if the average customer service phone call duration exceeds 20 seconds and if the rate of generic drug dispensing is not at least 80% of all drugs dispensed on behalf of members of the plans.

ESI provided no information regarding compliance with these guarantees.

Conclusions

The comments made regarding the contract with the Association apply to the contract with MUS. In addition, we conclude the MUS and ESI should agree to continue to the education program or remove the provision from the contract.

FIB CONTRACT

ESI and FIB have entered into an agreement which was renewed as of April 1, 1999. The terms of the agreement relate to the specifics of the FIB plan provisions. However, the terms of the Association agreement also apply to FIB. We conclude that ESI is not in compliance with the terms of its agreement with FIB in the same areas in which they do not comply with the Association's agreement.

MPC CONTRACT

ESI and MPC have entered into an agreement which was renewed as of April 1, 1999. The terms of the agreement relate to the specifies of the MPC plan provisions. However, the terms of the Association agreement also apply to MPC. We conclude that ESI is not in compliance with the terms of its agreement with MPC in the same areas in which they do not comply with the Association's agreement.

VII - COORDINATION OF BENEFITS AND SUBROGATION

Both the agreement with the Association and the agreement with MUS contain provisions regarding the processing of prescription drugs for participants who have duplicate health care coverage. Neither contract contains a provision regarding ESI's involvement in subrogation activities. Information regarding our review activities and findings is presented below.

COB PROVISION

The COB provision in the agreements calls for ESI to "manage a Coordination of Benefits program for Members who have other coverage".

Under the agreements, the plan sponsors are to provide ESI information regarding other prescription drug benefits as part of the eligibility process. Those participants who have other coverage that has liability primary to the ESI coverage must then submit a paper claim plus an Explanation of Benefits form from the other coverage in order to receive reimbursement for prescriptions.

Claims involving COB are received in the claim department in Tempe, Arizona. Claims are not date stamped to show the received date.

Information regarding the claim is entered into the system along with payment information from the primary plan's EOB. The system calculates the regular plan benefit and the payment amount.

COB DATA

COB data are not being provided to ESI. When the State first adopted the ESI program, COB data from BCBSMT was provided to ESI. However, no further information has been provided by the State or BCBSMT.

COB data are not being provided to ESI by or on behalf of any of the other 3 plan sponsors.

As a result, the COB provision is ineffective except for those individuals employed by the State whose COB data was provided to ESI several years ago.

We supplied BCBSMT with a listing of claims in our sample for the State, MUS and MPC and requested that they provide us with information from their files regarding the existence of other health care coverage. We also requested the same information from IAI for FIB. Our findings are presented below.

Sponsor	Claims	Other Plan Primary
State	113	0
MUS	61	1
MPC	28	2
FIB	9	1

Based on the results of our review, we conclude that the Plan Sponsors are not actively providing ESI the information to manage the COB provision. We further conclude that claim costs, in aggregate, would be lower for the plan sponsors, if the COB information were made available to ESI.

SUBROGATION

Neither the ESI agreement with the Association nor MUS contain a provision regarding subrogation.

VIII - OTHER CLAIM ISSUES

Discussion regarding other claim issues is presented below.

REBATE PERCENTAGE

We recalculated the plan sponsor's share of the formulary rebate for all the plan sponsors. Although no exceptions were noted, we did observe that MUS's percentage (75%) was less than the other three plan sponsors (80%). We believe MUS might obtain a more favorable formulary rebate percentage when renegotiating their contract with ESI.

BENEFIT STRUCTURE

We reviewed each plan document for the period covered by the audit to gain information regarding the appropriate deductible, copay and out-of-pocket limit.

The claims in our sample were reviewed to determine that each was paid according to the benefit structure for each plan. We have discussed our findings regarding benefit structure along with the results of our recalculation of each sample claim. Findings regarding benefit structure are restated below along with information not directly related to the sample claims.

Deductible and Copay

Several sample claims resulted in a copay which, in total, exceeded the out-of-pocket limit for the plan year.

IX - LOGIC AND OTHER TEST RESULTS

This section presents the results of test claims submitted to the ESI claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

ESI informed us that due to recent acquisitions and changes in security codes in the Anchor system, we were unable to test paper claims. ESI stated that the paper claims can only be submitted to the real-time system and therefore would be released for payment.

We created a total of 6 fictitious electronic claims . Working with a claim processor in the claim department and a specialist in the training area in St. Louis. These claims were submitted to the system for processing. The electronic claims were submitted to the system in a test mode. Each claim was then resubmitted twice; once with the billed amount changed and once with the provider code changed.

OTHER CLAIM TESTS

We also created a series of additional fictitious claims (5 each) for the following situations.

- Claims for terminated employees.
- Claims for a terminated dependent.
- Claims from a fictitious provider.
- Claims for drug prices in excess of the contract price.
- Claims for medication inconsistent with the patient's sex.

FINDINGS

Our findings are presented as **Exhibit C** and discussed below.

Logic Claims

The system is designed to receive claims electronically from a pharmacist and reimburse the pharmacist. Our first logic test involved resubmitted claims by the same pharmacist on the same date with a different ingredient cost. The system identified these

claims as duplicates.

Our second test involved resubmitted claims with a different pharmacy number. The system identified these claims as duplicates.

Claim For Terminated Individuals

If the termination date for an employee is recorded in the claim system, no claims will be paid if the dispensing date follows the date of termination. All 5 of such test claims were rejected.

Claim For Terminated Dependents

If the termination date for an dependent is recorded in the claim system, no claims will be paid if the dispensing date follows the date of termination. All 5 of such test claims were rejected.

Claims From a Fictitious Provider

The system will only process electronic claims submitted by pharmacists that participate in the ESI program. Claims from non-participating pharmacists will be rejected. All 5 test claims for a non-participating pharmacy were rejected.

Excessive Price

We submitted claims for prescriptions using ingredient costs that were in excess of the contracted ingredient. The ESI system properly reduced the payment to agree with the contractual price.

We identified 5 claims in our audit sample that were paid using an ingredient cost other than the contractual price.

ESI advised us that there is no dollar edit in their system.

Drug Inconsistent with Patient's Sex

We submitted 5 fictitious claims for sex specific medication using the incorrect sex for the patient.

The ESI system failed to identify this inconsistency in all 5 claims. ESI informed us that the system does not have age or gender edits.

SUMMARY

Based on our test results, we conclude that the ESI system is effective in identifying erroneous claims except in the following areas:

- Drugs which are inconsistent with the patient's sex.
- Claims with excessive prices.

We believe the Plan Sponsors should advise ESI to use the features, in their system, to detect Drug-Gender inconsistencies and Drug-Age inconsistencies.

No other exceptions were noted.

X - CONCLUSIONS AND RECOMMENDATIONS

We performed our audit based on the services requested and agreed upon in our audit contract. Claim payment accuracy was determined based upon the provisions in the documents describing the prescription drug benefit plan of each plan sponsor. Determinations of compliance with technical aspects of the services provided by ESI were measured against the language in the agreements between the ESI and the various plan sponsors and the Association.

Policies and procedures employed by ESI were not viewed as appropriate documentation if they were not supported by documentation agreed to by the plan sponsors and/or the Association.

Presented below are our conclusions and recommendations regarding those aspects of the plan which we believe could benefit from revision.

CLAIM PAYMENT

Presented below are the comments and recommendations related to claim payments.

Claim Processing Accuracy

The results of our audit reveal that the ESI system is not capable of processing claims with a high degree of accuracy.

We recommend the following:

- ESI should immediately review the programming errors (incorrect discounts, incorrect administration fees, etc.) we identified, in order to process claims according to the contract with the Association.

- The Association should immediately impose performance standards that include penalties payable by ESI if standards are not met. For example, accuracy rate should be equal to or better than 98% and dollar accuracy should be equal to or better than 99%.

- ESI should review all history and identify the overpayments caused by the system errors and refund the money to the Association.

- ESI should provide monthly progress reports to the Association until the steps described above are complete.

Copayment

ESI is not capable of limiting the out-of-pocket expenses for a participant or family to the contractual amount. ESI management appeared to be aware of this system limitation. This system limitation appears to place ESI in violation of their agreement to administer the benefit plan sponsored by the State.

We recommend the following:

- ESI should immediately revise their claim processing software so that it is capable of processing plan claims as agreed upon with the State.
- ESI should immediately begin a program of manual review of all State claims to assure that out-of-pocket limits are not exceeded. This manual review should continue until the software revision is proven effective.
- ESI should immediately review all State claim history to identify individuals and families that have been charged more than the contractual copay and deductible. Refund checks should be sent to each over charged person.
- ESI should provide a monthly progress report to the State until these steps have been completed.

Paper Claims

Each of the agreements calls for payment of paper claims (not COB) using a reimbursement no less favorable than a system processed claim for a network pharmacist.

In actual practice, ESI has paid some paper claims based on the actual billed charges. Five claims in our sample were paper claims where the payment was based on billed charges that exceeded AWP less the discount.

We recommend the following:

- ESI should begin processing paper claims in compliance with the agreements.
- ESI should research the claim history for all plan sponsors to identify overpaid paper claims. Refunds should be issued to each sponsor.
- ESI should provide monthly status reports until the refunds have been issued.

COB CLAIMS

The State is the only one of the four plan sponsors that has ever supplied COB data to ESI. COB data from the State were provided once and the data has never been updated.

We suggest that all four sponsors review this plan provision. If they determine that the COB provision should be utilized, periodic COB data should be provided to ESI so that savings can be obtained.

PARTICIPANT CONFIRMATIONS

We experienced significant resistance to our efforts to obtain confirmations from plan participants. We believe confirming the receipt of prescriptions is an important control factor for all four sponsors to utilize. We also believe participants should be encouraged to respond to confirmation request.

A failure to confirm the receipt of a prescription may indicate that the drug was not dispensed or it may be an indication of fraud or other inappropriate activity.

We suggest that confirmations should be requested on plan sponsor letterhead to emphasize the official nature of the correspondence.

DRUG UTILIZATION REVIEW

We were unable to confirm that the DUR system was effective. We reviewed several activity reports for participants that indicated that refills were processed too soon after the initial prescription was filled. Test claims for medication inconsistent with the patient's sex were processed to completion.

ESI maintains that their DUR system is working properly.

We recommend that ESI provide a detailed report of DUR activity during the audit period to support their statement that the DUR system is effective. Illustrations of each of the contractual edits should be included in the report.

Exhibit A

EXPRESS SCRIPTS PHARMACY CLAIMS
JULY 1, 1999 - JUNE 30, 2000 CLAIM AUDIT
DESCRIPTION OF ERRORS

Description	NABP #	Script #	Date Filled	Drug NDC	Plan Cost	Audited Amount	Difference
ESI used an outdated AWP price.	270534	6024681	9/10/1999	75245001	265.35	281.71	(16.36)
ESI incorrectly calculated the co-pay.	270489	202729	8/24/1999	56017270	13.95	13.76	0.19
Incorrectly applied a generic discount for a brand name drug.	270534	3018422	5/23/2000	61113000168	67.75	103.34	(35.59)
Claim should have been processed using the U&C amount.	130686	7000054	4/10/2000	2831501	16.50	15.70	0.80
Incorrectly calculated the ingredient cost.	270370	24282	9/9/1999	46086681	22.98	22.26	0.72
Incorrectly calculated the ingredient cost.	270534	6023527	9/1/1999	186074231	295.81	292.23	3.58
ESI should have used the U&C to calculate the ingredient cost.	270534	3011073	7/1/1999	59911587001	182.31	94.22	88.09
ESI incorrectly calculated the ingredient cost.	270440	6784767	4/21/2000	173047800	127.08	-	127.08
ESI charged $2.65 for an administration fee, it *should have been* $0.33.	270575	147838	12/26/1999	300304613	73.07	70.65	2.42
ESI charged $2.15 for an administration fee, it should have been $0.33.	270501	6165773	12/27/1999	300304613	102.75	100.93	1.82
ESI should have calculated ingredient cost using the AWP, which was less than MAC. The charges were lower than the co-pay, therefore the patient was overcharged $2.49.	60687	6502745	8/7/1999	53489014001		-	-
ESI calculated the ingredient cost using an outdated AWP.	270501	6158463	10/5/1999	87606005	55.47	59.19	(3.72)
ESI calculated ingredient cost using U&C when they should have used AWP.	270534	7014904	7/19/1999	2821501	21.89	20.00	1.89
ESI calculated ingredient cost using U&C when they should have used AWP.	270623	312055	12/6/1999	777310502	141.73	139.76	1.97
ESI calculated ingredient cost using the pharmacy's U&C, instead of ESI's U&C amount.	270512	506884	2/13/1999	71015623	235.52	235.02	0.50
A $10 co-pay should have been applied. This was due to an ESI system problem.	270534	6028291	11/16/1999	85125801	3,776.83	3,766.83	10.00
A $10 co-pay should have been applied. This was due to an ESI system problem.	270534	6040769	1/27/2000	85125801	3,776.83	3,766.83	10.00
ESI incorrectly calculated the ingredient cost.	270534	3013021	3/22/2000	85125801	3,869.96	3,792.00	77.96
ESI used incorrect discount amount for the mail order drug.	270534	6042095	2/14/2000	29321120	180.07	175.69	4.38

Exhibit A Continued

EXPRESS SCRIPTS PHARMACY CLAIMS
JULY 1, 1999 - JUNE 30, 2000 CLAIM AUDIT
DESCRIPTION OF ERRORS

Description	NABP #	Script #	Date Filled	Drug NDC	Plan Cost	Audited Amount	Difference
ESI used incorrect discount amount for the mail order drug.	270534	6033154	3/6/2000	173045301	133.21	130.00	3.21
ESI used incorrect discount amount for the mail order drug.	270534	4042788	2/22/2000	9005501	114.30	111.41	2.89
ESI used incorrect discount amount for the mail order drug.	270534	6017671	1/31/2000	25152531	375.66	366.94	8.72
ESI used the generic discount amount for a brand name drug.	270534	6009903	9/24/1999	186074282	199.63	310.81	(111.18)
ESI used incorrect discount amount for the mail order drug.	270534	6019248	5/19/2000	71036232	56.43	54.97	1.46
ESI used incorrect discount amount for the mail order drug.	270534	6048716	5/2/2000	62190115	66.49	61.71	4.78
Paper claim. ESI used submitted cost instead of the contracted network rate. This caused an overstatement to the deductible of $6.67.	111111	6769704	12/3/1999	6071758	1.50	1.50	-
Paper claim. ESI used submitted cost instead of the contracted network rate.	111111	21826	2/25/2000	54569467102	62.70	29.44	33.26
Paper claim. ESI used submitted cost instead of the contracted network rate.	111111	26822	2/18/2000	50242001820	3,301.50	2,143.50	1,158.00
Paper claim. ESI used submitted cost instead of the contracted network rate.	111111	26032	9/16/1998	50242007202	3,301.50	2,143.50	1,158.00
Paper claim. ESI used submitted cost instead of the contracted network rate.	111111	26822	12/7/1998	50242001820	3,301.50	2,143.50	1,158.00
				TOTAL	$ 24,140.27	20,447.40	3,692.87

Exhibit B

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
CLAIM PAYMENT TIME

Information regarding the time required for ESI to pay the pharmacist following the dispensing of a prescription under the electronic claim system.

MEASURE	STATE	MUS	MPC	FIB
Mean	8.99	20.59	7.28	18.22
median	7	15	7	23
Mode	1	1	3	23

Information regarding the time required for ESI to pay the participant following the dispensing of a prescription for paper claims.

MEASURE	STATE	MUS	MPC
Mean	89.67	24.33	5
median	7	8	5
Mode	7	N/A	5

Percent Paid on Day Following Dispensing for State

Day	# of Claims	% of Claims
1	12	5.69%
2	11	5.21%
3	8	3.79%
4	6	2.84%
5	4	1.90%
6	8	3.79%
7	7	3.32%
8	5	2.37%
9	5	2.37%
10	3	1.42%
11	5	2.37%
12	9	4.27%
13	5	2.37%
14	6	2.84%
15	3	1.42%
16	6	2.84%
17	2	0.95%
18 thru 30	0	0.00%
Total	105	92.92%

Percent Paid on Day Following Dispensing for MUS

Day	# of Claims	% of Claims
1	5	8.20%
2	0	0.00%
3	2	3.28%
4	1	1.64%
5	1	1.64%
6	2	3.28%
7	0	0.00%
8	3	4.92%
9	1	1.64%
10	1	1.64%
11	2	3.28%
12	3	4.92%
13	1	1.64%
14	3	4.92%
15	2	3.28%
16	0	0.00%
17	1	1.64%
18	2	3.28%
19	2	3.28%
20	1	1.64%
21	0	0.00%
22	2	3.28%
23	1	1.64%
24	0	0.00%
25	2	3.28%
26	2	3.28%
27	1	1.64%
28	4	6.56%
29	3	4.92%
30	2	3.28%
Total	50	95.08%

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
CLAIM PAYMENT TIME

Percent Paid on Day Following Dispensing for MPC

Day	# of Claims	% of Claims
1	1	3.57%
2	2	7.14%
3	4	14.29%
4	3	10.71%
5	1	3.57%
6	2	7.14%
7	3	10.71%
8	2	7.14%
9	1	3.57%
10	2	7.14%
11	2	7.14%
12	1	3.57%
13	0	0.00%
14	2	7.14%
15	2	7.14%
16 thru 30	0	0.00%
total	28	100.00%

Percent Paid on Day Following Dispensing for FIB

Day	# of Claims	% of Claims
1	1	11.11%
2 thru 11	0	0.00%
12	1	11.11%
13	1	11.11%
14 and 15	0	0.00%
16	1	11.11%
17 thru 22	0	0.00%
23	3	33.33%
24 and 25	0	0.00%
26	1	11.11%
27	1	11.11%
28 thru 30	0	0.00%
Total	9	100%

Exhibit C

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
RESULTS OF SYSTEM TESTS

TESTS	RESULTS
LOGIC TESTS	
Billed Amount Electronic	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Claim 6	Pass
Pharmacy Number Change - Electronic	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Claim 6	Pass
Terminated Employee	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Terminated Dependent	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
EXPRESS SCRIPTS AUDIT
RESULTS OF SYSTEM TESTS

TESTS	RESULTS
Fictitious Provider	
Claim 1	Pass
Claim 2	Pass
Claim 3	Pass
Claim 4	Pass
Claim 5	Pass
Excessive Price	
Claim 1	Fail
Claim 2	Fail
Claim 3	Fail
Claim 4	Fail
Claim 5	Fail
Drug Inconsistent With Patient's Sex	
Claim 1	Fail
Claim 2	Fail
Claim 3	Fail
Claim 4	Fail
Claim 5	Fail

EXPRESS SCRIPTS
Charting the Future of Pharmacy

Exhibit D

Self Funded/Carrier Division

1700 North Desert Drive
Tempe, AZ 85281
www.express-scripts.com
602.225.0005

October 25, 2000

Wolcott & Associates
10977 Granada Lane, Suite 103
Overland Park, KS 66211
Tele – 913-661-9440...fax-913-491-4974

RE: State of Montana
First Interstate Bank
University of Montana
Montana Power

Corporate Headquarters
Maryland Heights, Missouri

Albuquerque, New Mexico
Bensalem, Pennsylvania
Bloomington, Minnesota
Farmington Hills, Michigan
Horsham, Pennsylvania
Tempe, Arizona
Troy, New York
Toronto, Ontario

Responses prepared by Account Manager Cyndi Olivarez. Please don't hesitate to contact for any additional information or clarification.

Response to Types of Errors (section II- 3)
ESI has identified 7 claims (all for MUS) which did pay incorrectly due to the manual entry of an expiration date of 12/31/99 in a billing code reference field. This was corrected by Quality Assurance on 7/18/00. It is known that this billing code was set up solely on the MUS group and solely impacted the Albertson's Mail Order Pharmacy. Due to a 12/31/99 expiration date, the system automatically defaulted to the network billing code of 12%. This being a measurable and definable issue, ESI will take the necessary steps to re-process and correct the error.

To address the 2 errors that occurred due to the AWP pricing having been updated with a backdated effective date. The AWP pricing is updated manually, the majority of the pricing is changed on the same day as the effective date, however, due to weekends, holidays etc. there can be a slight discrepancy.

The 5 paper claims were processed based on billed rather than AWP less the discount at the client's request. Member Submitted claims can be processed at the Actual Cost when the client requests that we "pay as par" so that the member is not penalized if they do not utilize a participating pharmacy as non-participating pharmacies are not contracted and therefore, do not honor the same discounts and pricing that participating pharmacies do.

Response to Out-Of-Pocket Limit (section II- 5)
ESI's system does keep track of a cumulative total for each individual's out of pocket. If however, a member transfers to another ID number under the same group due to circumstance such as marriage, divorce, COBRA, death of a spouse, etc, the deductible and out of pocket maximums will not follow the individual. The out of pocket maximum and the deductible are tracked by ID number rather than be name. The client has been made aware of the and forward names and ID numbers of members who have transferred ID numbers to the ESI Account Management Team to transfer the amount they have accumulated. Members are manually reimbursed for claims paid over and above their maximums' by submitting receipts.

Response to First Interstate Bank (section IV-3)
IAI is now sending a file to ESI weekly and ESI performs a reconciliation which terminates members by absence. This system was implemented to prevent terminated employees from being able to utilize their prescription drug cards. Prior to IAI processing First Interstate Banks' eligibility files, the files were supplied to ESI by First Interstate and were maintained by the client themselves.

Response to Paper Claims Results (section V-1)
This time frame was being dramatically impacted by claims submitted by DPHHS and were to be reconciled on a spreadsheet and then mailed back with a check. This was not only time consuming, but proved to be ineffective as well. Effective February of 2000, ESI's Account Management Team revised and streamlined this process.

Response to ESI personnel responsible for updating the administration fees based on changes to plan provisions appear to be inconsistent with agreed upon fees in the contract. (sectionVI-3)
Administration fees were updated in accordance with the backdated contract, Account Management cannot change the administration fees without the written consent of the client, the effective date of the amendment and the actual implementation dates were in conflict.

Response to ESI personnel responsible for payment on member submitted claims is inconsistent with agreed upon payments in the contract. (section VI-3)
Member Submitted claims can and are frequently processed at the Actual Cost per the client's instruction

Response to Drug Utilization Review (section VI-4)
As the DUR pertains to member submitted claims entered with a one day supply in the system. The edit set up to read the days supply, but it also verifies the NDC and the quantity, therefore, while this may be possible to get an early refill, it is not highly probable.

Response to Coordination of Benefits Claim Processing(section VI-4)
Benefits Administrators at the State regularly submit COB claims and pertinent documentation, in addit to entering members who are eligible for COB into the group designated for coordination of benefits. Th other 3 plan sponsors do not offer a COB benefit at this time.

Response to Incentive Payments and Rebates (Section VI-5)
Manufacturer agreements are confidential and proprietary between ESI and the manufacturer. ESI is properly incensed to maximize the total rebate in which the client and ESI then share.

Response to Performance and Cost Saving Guarantees (section VI-6)
A report reflecting the 1999 Performance Guarantees was provided to the Client in February 2000. The 2000 results will be available in February 2001 as they are measured and reported on an annual basis.

Response to COB Data (section VII-1)
As stated above, the Benefits Administrators for the State send COB members over in the eligibility tape they send and they also review and submit claims and any additional documentation necessary to process these claims. None of the other 3 clients have a COB benefit at this time.

Response to Deductible and Copay (section VII-1)
As with Out-of –Pocket Maximums, deductibles accumulated are not tracked by name, but rather by ID number, when changes occur these must be transferred manually and the clients do provide us with this information so we can update our system and see that members are reimbursed accordingly.

Response to Drugs Inconsistent with Patient's Sex (section IX-2)
The ESI DUR system does have a feature to detect Drug-Gender Alert and Drug-Age Precaution. This is only in effect when the Client chooses to implement this feature.

In conclusion, ESI continues to strive to improve service and systems on an ongoing basis. The MAHCP is a valued customer and while we recognize that there are ongoing issues, we continue to work with our clients to improve our processes both internally and externally. In the next year, will be migrating our clients to a new and improved adjudication system which has been utilized with proven accuracy by DPS (the same claims adjudication system currently utilized to service BCBS of Montana clients). ESI anticipates that MAHCP clients will realize the same benefit when they have been migrated to the new adjudication platform.

Again, if you have any questions, please feel free to contact me at (800)955-4879 Ext. 33115.

Respectfully,

Cyndi Olivarez

Cyndi Olivarez
Account Manager

cc: Christina Norman
Sharon Reed
MACHP (State of Montana, Montana University Systems, Montana Power, First Interstate Bank

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

Exhibit E

MARC RACICOT, GOVERNOR

MITCHELL BUILDING, ROOM 130
PO BOX 200127

STATE OF MONTANA

(406) 444-3871
FAX: (406) 444-0544

HELENA, MONTANA 59620-0127

November 8, 2000

Marie Richman, Vice President
Wolcott & Associates, Inc.
10977 Granada Lane, Suite 103
Overland Park, Kansas 66211

Dear Ms. Richman:

We received your draft report on the State of Montana Prescription Drug Claim Audit for the period July 1, 1999, through June 30, 2000, and we provide the following responses to your audit findings and recommendations.

Claim Processing Accuracy

RECOMMENDATIONS:

(1) Express Scripts (ESI) should immediately review the programming errors (incorrect discounts, incorrect administration fees, etc.) identified, in order to process claims according to the contract with the Association.
(2) The Association should immediately impose performance standards that include penalties payable by ESI if standards are not met. For example, accuracy rate should be equal to or better than 98% and dollar accuracy should be equal to or better than 99%.
(3) ESI should review all history and identify the overpayments caused by the system errors and refund the money to the Association.
(4) ESI should provide monthly progress reports to the Association until the steps described above are complete.

RESPONSE: We concur with recommendations 1 and 4. Recommendation 2, imposition of performance standards and penalties, would require an amendment to the contract between the Association and Express Scripts. We concur with recommendation 3, however, refund of any overpayments should be made to the client members of the Association, including the State of Montana Employee Benefits Plan, rather than the Association.

Copayment -- limiting copayments to the annual out-of-pocket maximum

RECOMMENDATIONS:

(5) ESI should immediately revise their claim processing software so that it is capable of processing plan claims as agreed upon with the State.
(6) ESI should immediately begin a program of manual review of all State claims to assure that out-of-pocket limits are not exceeded. This manual review should continue until the software revision is proven effective.
(7) ESI should immediately review all State claim history to identify individuals and families that have been charged more than the contractual co payment and deductible. Refund checks should be sent to each person that is over charged.
(8) ESI should provide a monthly progress report to the State until these steps have been completed.

RESPONSE: It is our understanding that ESI correctly tracks cumulative annual deductibles and out-of-pocket maximums as long as a member maintains the same ID number throughout the year. There are several situations under which a member may transfer coverage to another ID --for example, a dependent spouse, whose claims are processed under his wife's ID, obtains State employment and transfers coverage to his own ID. In these situations, ESI's system does not know to credit deductible and co-payments to the new ID. It is our understanding that this credit is manually entered upon notice of the transfer in coverage from one ID to another. Failure to credit prior deductible and co-payments under a different ID can be due to (1) failure of the member to specify that their new coverage is really a transfer from another ID, (2) failure of the Employee Benefits Bureau to transmit this information to ESI, or (3) failure of ESI to manually record the appropriate credit.

If ESI's system is failing to appropriately credit cumulative annual deductibles and out-of-pocket maximums for members without a change in ID, we concur with the above recommendations. If the problem is primarily confined to ID change situations, we may need to redouble State efforts to identify transfers from one ID to another. This information is requested on the form for adding, changing and deleting coverage but we may need to stress the importance of this information with Agency benefits personnel, who assist members in completing the form.

Paper Claims -- accuracy and timeliness

RECOMMENDATIONS:

(9) ESI should begin processing paper claims in compliance with the agreements.
(10) ESI should research the claim history for all plan sponsors to identify overpaid paper claims. Refunds should be issued to each sponsor.
(11) ESI should provide monthly status reports until the refunds have been issued.

RESPONSES: We partially concur with these recommendations. There are certain paper claims, for which the State Employee Benefits Plan staff requests that ESI process "at par." These claims may be processed at billed charges, rather than the discounted network allowable price, in order to hold the plan member harmless for the additional charges. A number of these exceptions were authorized, when conversion to a new benefits Software system delayed transmission of correct eligibility information to Express Scripts. In this instance, Plan members were forced to obtain prescriptions before their Express Scripts eligibility could be verified and submit paper claims. These were correctly processed as exceptions to the client agreement and should not be considered overpayments. If claims are paid based on billed charges without the pre-authorization of the State Plan, the claims should be considered overpayments and refunded.

We concur that the timeliness of paper-claim processing needs to be improved. ESIs response to the excess processing time sited in V-1 of the report refers to DPHHS claims, which are not part of this contract.

COB Claims

RECOMMENDATIONS:

(12) COB (Coordination of Benefits) data from the State was provided once (to ESI) and the data has never been updated. It is suggested that the sponsors review this plan provision. If they determine that the COB provision should be utilized, periodic COB data should be provided to ESI so that savings can be obtained.

RESPONSE: COB information is regularly supplied and actively applied by ESI for spouses and dependents that have other prescription drug coverage. These individuals are identified as COB and classified under a separate group number (01918). Individuals in this group are blocked from having a prescriptions filled under the card program and must, and do, submit paper claims to claim secondary reimbursement. The COB data is updated each biweekly payroll cycle on the eligibility tape transmitted by the Employee Benefits Bureau to ESI. COB data also is updated manually by the Employee Benefits Bureau between tape cycles as necessary when new information is received.

Participant Confirmations

RECOMMENDATION:

(13) It is suggested that confirmations sent to plan participants should be requested on plan sponsor letterhead to emphasize the official nature of the correspondence.

RESPONSE: We concur with this recommendation.

Drug Utilization Review

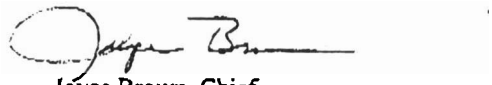
RECOMMENDATION:

(14) It is recommended that ESI provide a detailed report of Drug Utilization Review (DUR) activity during the audit period to support their statement that the DUR system is effective. Illustrations of each of the contractual edits should be included in the report.

RESPONSE: We concur with this recommendation

Thank you for the opportunity to respond.

Sincerely,



Joyce Brown, Chief
Employee Benefits Bureau

Exhibit F

MONTANA UNIVERSITY SYSTEM
OFFICE OF COMMISSIONER OF HIGHER EDUCATION

2500 BROADWAY ◊ PO BOX 203101 ◊ HELENA, MONTANA 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

November 9, 2000

Ray Wolcott, Jr. C.F.E.
Wolcott & Associates, Inc
Suite 103
10977 Granada Lane
Overland Park, KA 66221

Dear Mr. Wolcott:

Thank you for the opportunity to respond to your claims audit of the Express Scripts administered pharmacy plan for Montana University System Employees. In general I agree with your recommendations concerning Express Scripts. I would like to address the suggested recommendations on the part of the University System.

PARTICIPANT CONFIRMATIONS

We will send you an informational letter on our letterhead to send along with your information to the selected plan participants validating your request for information. We will also include this information regarding this process in our newsletter and other educational materials.

PAPER CLIAMS

ESI has paid the paper claims submitted correctly according to our request. We do however have language in our contract with ESI that states a member will not be reimbursed more than the Prescription Price less the Member's deductible and co-payment. We will contact ESI and discuss the definition of this language so claims are not over paid for out of network use.

COB CLAIMS

As suggested we will review the Coordination of Benefits provision of our agreement and if we determine that the COB provision should be utilized, we will provide ESI with COB data. We will discuss this with both ESI and Blue Cross Blue Shield of Montana (BCBSMT). BCBSMT administers the COB provisions of our health plan.

The Montana University system will follow-up with Express Scripts on the other audit recommendations that indicated problems with their plan administration, especially those which could lead to a recovery of funds from ESI and those which could lead to better service to our plan members.

Glen D. Leavitt
Director of Benefits